WELLFLEET
WORKPLACE

Portability Request Form

THIS FORM MUST BE RECEIVED WITHIN 60 DAYS IMMEDIATELY FOLLOWING THE TERMINATION OF COVERAGE UNDER THE GROUP POLICY

Mail, fax or email your application and payment to:

Wellfleet Insurance Company
1500 Main Street, Suite 1000
Springfield, MA 01115

Email: workplaceclaims@wellfleetinsurance.com **Phone: 855-664-5838** **Fax: 413-452-5486**

TO BE COMPLETED BY INSURED EMPLOYEE:		
Date of Request:	Name of Employer:	
Policy Certificate Holder Number:	Insured's SSN:	
Insured's First Name:	Middle:	Last Name:
Insured's Address: Street:		
City:	State	Zip Code:
Phone Number:	Email Address:	Employment Termination Date _____/_____/_____

COMPLETE THE FOLLOWING IF DEPENDENTS ARE INSURED UNDER THE GROUP POLICY							
First	Last	DOB	Sex	First	Last	DOB	Sex
Spouse				Child			
Child				Child			
Child				Child			

PREMIUM PAYMENT OPTIONS

☐ Automatic Bank Draft (complete Automatic Withdrawal Authorization form) ☐ Direct Bill

PREMIUM PAYMENT FREQUENCY

☐ Monthly (Bank Draft only) ☐ Quarterly ☐ Semi-annually ☐ Annually

If selecting Direct Bill, a check with the first payment must accompany this application. ***If monthly frequency is selected, please complete the Automatic Withdrawal Authorization).***

The check amount should be based on the payment frequency you select above (i.e. if you selected quarterly, the check amount should be 3 times your current monthly premium).

Please make the check payable to: Bay Bridge Administrators, LLC.
I hereby agree to continue my insurance under the group policy outlined above

Signature of Insured: _____ **Date:** _____

AUTOMATIC WITHDRAWAL REQUEST AUTHORIZATION

Name on Account:

_____ ___ _____

First Name MI Last Name

SSN: _____

Address on Account:

_____ _____ ____ _____

Street Address City State Zip

Phone: _____ **Email:** _____

Banking Information:

_____

Bank Name

_____ _____ **Account type**: ☐ Checking

Routing Number (9 digits) Account Number ☐ Savings

ATTACH VOIDED CHECK HERE

I (we) authorize Wellfleet Insurance Company. to initiate automatic withdrwals from my (our) account indicated above.

_____ _____

Authoirzed Signature Date

Please return form with filed claim to: **Wellfleet Insurance**
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Springfield, MA 01115
Email: workplaceclaims@wellfleetinsurance.com
Phone: 855-664-5838
Fax: 413-452-5486